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Nov.)

Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION NOVEMBER 1981 ISSUE #1

MEDICAID MEDICARE EXCHANGE

HCFA RO INFORMS STATES OF VALUABLE TPL INFORMATION

The Oregon Medicaid agency recently informed the Seattle regional HCFA office of a problem in recovering third party resources available through the Medicare program. The Oregon Medicaid agency was unable to get reimbursement directly from Medicare for Part B claims paid incorrectly by Medicaid.

The regional office referred Oregon to Section 3006, Part B of the Medicare Carriers Manual which tells a State Medicaid agency exactly how to receive direct Medicare reimbursement. Idaho and North Carolina have also been informed of the availability of these procedures.

Since Oregon implemented these procedures, they have billed Medicare for $50,000 of Part B claims erroneously paid by Medicaid. Oregon estimates that annual recoveries will be between $300,000 and $400,000.

For further information about this valuable resource, contact Steve Moses, Region X, 206-442-7806, FTS 399-7806. ●

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OMNIBUS RECONCILIATION ACT OF 1981 AFFECTS HCFA PROGRAMS

On August 13 H.R. 3982 was signed into law (P.L. 97-35). This law, the Omnibus Reconciliation Act of 1981, includes many provisions affecting Medicaid, Medicare, and Professional Standards Review Organization (PSRO) programs. Following are some important provisions of that law according to the Office of Legislation and Policy's "HCFA Legislative Summary" dated August 26, 1981:

- Establishes under Medicaid State plans and Medicare a transitional allowance for the closure, or conversion to approved use, of underutilized bed capacity or services. A hospital must have a determination made on whether it is eligible for a transitional allowance prior to undergoing actual closure or conversion. (Effective for services furnished during an accounting year beginning on or after October 1, 1981.)

- Repeals the coverage of inpatient services provided in free-standing alcohol detoxification facilities. It also repeals the requirement for certain studies and demonstration projects. (Applies to inpatient stays beginning the 10th day after enactment.)

- Raises to $45 the base of the formula that is used in the determination of the Part A deductible. Coinsurance amounts will be figured on this new amount. Also increased is the Part B deductible, from $60 to $75. (Effective January 1, 1982.)

- Reduces Medicare reimbursement limits currently applied to hospital inpatient routine operating costs from 112 to 108 percent of the mean or such other comparable or lower limits as the Secretary may determine. The Secretary may provide for exemptions and exceptions to this limitation as he deems appropriate. (Applies to cost reporting periods ending after September 30, 1981; however, in the case of a cost reporting period beginning before October 1, 1981, the lower limit will be applied only to that portion of the reporting period occurring after September 30, 1981.)

- Repeals Medicare Part B continuous open enrollment and reinstitutes the general enrollment period which occurs January 1 through March 31 of each year. Coverage then becomes effective July 1. (Effective October 1, 1981.)

- States electing to include students aged 18 through 20 under AFDC are not required to provide Medicaid coverage to persons under 21 who would be eligible for AFDC if attending school; coverage of these individuals is optional. States choosing to provide Medicaid coverage to children not receiving AFDC may limit such coverage to children under 21, 20, 19, or 18, or any reasonable category of such children. (Effective August 13, 1981.)

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P.L. 97-35 - continued from page 2

- Repeals the reasonable charge limit requirement, as well as the requirement that State plans provide for methods and procedures to assure that payments are not in excess of reasonable charges. (Effective for services furnished on or after October 1, 1981.)

- Repeals the AFDC penalty provisions. State Medicaid plans are required to provide for informing all Medicaid eligibles under 21 of the availability of EPSDT services and for arranging for screening and treatment services. (Both the repeal of AFDC penalty, and the State Medicaid plan requirements were effective October 1, 1981.)

- States need not collect third party liabilities in cases where the amount the State can reasonably be expected to collect is less than the costs of recovery. (Effective August 13, 1981.)

For further information about this law, or any other legislation affecting Medicaid and/or Medicare programs, call HCFA's Office of Legislation and Policy at 202-426-3717.

MMMI EVENTS

State Medicaid Directors'
Mid-Year Conference
December 3-4 New Orleans, LA

Contact: Edward Palder
301-594-8940
FTS 934-8940

Carrier Representative Group
(CRG) Meeting
January 14 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

WATCH THIS SPACE FOR
ANNOUNCEMENT OF
ADDITIONAL PROGRAMS

MASSACHUSETTS BLUE SHIELD SUCCESSFULLY RECOMPETES FOR MAINE PART B BUSINESS

Blue Shield of Massachusetts (BSM) was awarded the first experimental Medicare Part B competitive fixed-price contract in July 1977. In June 1981, after recompeting for the new Part B carrier contract, HCFA awarded BSM the first competitive procurement to have an incentive payment provision. Under this new contract, BSM is entitled to receive additional specified monetary payments if specified performance levels are exceeded.

The new 1981 contract costs $9,866,706, and will run from June 1, 1981, to September 30, 1984. The original 1977 contract was for $5,285,000 with a one year extension given in 1980 at a negotiated fixed-price of $2,140,227. In September 1980 the projected savings from 1977 to 1980 was determined to be $772,556.

BSM has been Maine's Medicare Part B carrier since Union Mutual Insurance Company decided to discontinue participating as a Part B carrier in 1976. Rather than seeking another cost reimbursement contractor to replace Union Mutual, HCFA decided to select a replacement contractor by using the experimental authority under Section 222 of P.L. 92-603. Under Section 222, HCFA is permitted to experiment with a variety of methods of selecting and reimbursing Medicare contractors.

In March 1976, a Request for Proposal (RFP) was issued soliciting fixed-price proposals for a Maine Medicare Part B contractor. This Medicare experiment was the first involving a competitively let fixed-price Medicare contract which tested: the competitive method of selecting a Medicare contractor; the merits of fixed-price reimbursement for contractor administrative costs; and, contractor performance in providing accurate, timely, and satisfactory services to beneficiaries and providers.

The experimental contract provided an opportunity for the contractor to achieve a profit while at the same time expose itself to the risk of a loss if their management of the contract was ineffective or inefficient. Also, the contract contained provisions for the assessment of liquidated damages for each contract performance standard failed by the contractor.

HCFA AND NIAAA TESTING COST EFFECTIVENESS OF PROVIDING ALCOHOLISM SERVICES

HCFA and the National Institute for Alcoholism and Alcohol Abuse (NIAAA) have funded an eight-State demonstration to test the cost effectiveness of providing Medicaid and Medicare coverage for alcoholism treatment services in approximately 120 non-traditional settings. NIAAA transferred $1.1 million to HCFA for administrative costs of the eight grantees, and will continue to annually transfer $1.1 million during the four year demonstration period which began on September 30. HCFA granted the necessary Medicaid and Medicare waivers to permit payment for alcoholism services in freestanding inpatient and outpatient centers, and halfway houses. The centers will be given provider status under this demonstration.

The eight grantees are Michigan, Illinois, Arkansas, Oklahoma (focusing on American Indians), New York, New Jersey, Connecticut, and Georgia. Each State will administer and monitor approximately 15 treatment sites.

The demonstration will determine:

- the feasibility of providing Medicaid and Medicare reimbursement for alcoholism services in freestanding inpatient and outpatient centers, and halfway houses;
- the Medicaid and Medicare costs of providing health services in

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Trainers...Take Note!

As training monies become scarcer, you might consider producing a program at little or no expense to your agency. Other trainers have been successful with this approach, and they want to share their experience with you. As this column shows, television (TV) and radio stations are valuable resources in the free production of quality programs and spots.

The New Orleans Video Access Center (NOVAC), a non-profit community service organization, produced "Body Shop," a delightfully captivating 13 minute Early and Periodic Screening, Diagnostic and Treatment (EPSDT) tape which is shown to over 8,000 welfare applicants a month in Louisiana. This was produced at no expense to the Medicaid State agency. (Jane Jensen, 504-524-8626)

While NOVAC is unique to New Orleans, cable TV companies frequently have community access features as part of their franchise agreement. Depending on the agreement, trainers can learn how to produce a full length program or can actually produce one for viewing by cable audiences within the area.

In Massachusetts, cable TV invited Patricia Frieden from Blue Shield of Massachusetts (telephone 617-956-3448) to participate in three talk shows for senior citizens. The programs have been an excellent way to educate Massachusetts' senior citizens at no cost to the Medicaid program.

A staff member of the New Mexico State Agency saw an Alaskan EPSDT public TV spot and thought it was ideal for his State. Carlos Fierro (telephone 505-827-5551) used an EPSDT radio spot that Ricardo Montalban had made for New Mexico and, with HCFA's assistance, merged Mr. Montalban's voice-over with the scenic Alaskan shots. He is now planning a public service announcement in a Pueblo Indian dialect. (MMX #5/6, August/September 1981 includes an article on page 4 describing this project.)

The Dallas regional office wanted to publicize EPSDT. They developed a script, and a local TV station produced the spot. The regional office had elementary school students select their Dallas Cowboy football team hero. They chose Tony Hill who volunteered his time for the public service announcement. (Betty Collins 214-729-6481, FTS 729-6481). Kansas City and Seattle regional offices have also been successful in involving football stars in promoting preventive health care for children. (Bill Collins, 206-442-0436, FTS 399-0436).

These are just a few ideas. "Trainers Take Note" encourages you to talk to the trainers identified in this column and/or contact Susan Eberhard of M/MMI's Consultation and Training Branch at 301-594-8655, FTS 934-8655. ●

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Privacy Act of 1974: Report of Amended Routine Uses - Notification of Amended Routine Uses
07/20/81 Federal Register
Contact: Glenn J. Martin, 301-597-2999, FTS 987-2999

Equipment Acquired Under Public Assistance Programs - Notice of Proposed Rulemaking
07/24/81 Federal Register
Contact: Edward M. Tracy, 202-755-7633

Medicaid Program: Delegation of Authority to Issue Medicaid Disallowance Letters - General Notice
07/27/81 Federal Register
Contact: David McNally, 301-597-1397, FTS 987-1397

Medicaid and Medicare Programs: Schedules of Guidelines for Physical Therapy and Respiratory Therapy Services - Proposed Notice
08/13/81 Federal Register
Contact: William Goeller, 301-597-1802, FTS 987-1802

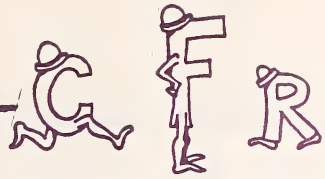
Conditions of Participation for Hospitals; Conditions for Coverage of Services of Independent Laboratories; Immunohematological Testing, Transfusion Services and Bloodbanking - Final Rule
08/14/81 Federal Register
Contact: Royal A. Crystal, 301-594-7910, FTS 934-7910

Medicare Program: Determinations of Payment Amount of Services Furnished by Independent Rural Health Clinics - Final Rule with a Request for Additional Comments
08/14/81 Federal Register
Contact: Bernadette Schumaker, 301-597-1048, FTS 987-1048

Medicaid Program: Miscellaneous Corrections - Correction of Final Rule
08/19/81 Federal Register
Contact: Julie Brown, 301-594-9636, FTS 934-9636

Medicaid Program: Extended Phase Out Provisions of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) Correction Plans - Notice of Proposed Rulemaking
08/24/81 Federal Register
Contact: Wayne Smith, Ph.D., 301-594-7651, FTS 934-7651

Medicaid and Medicare Programs: Reimbursement for Clinical Laboratory Services - Final Rule with Comment Period
08/24/81 Federal Register
Contact: Paul Riesel, 301-597-1843, FTS 987-1843



National Professional Standards Review Council; Meeting - General Notice
08/26/81 Federal Register
Contact: Cleo E. Hancock, Jr., 202-245-6097

Privacy Act of 1974; Report of New System - Notice of New System Records
09/02/81 Federal Register
Contact: Judith Sangl, 202-245-7586

National Professional Standards Review Council; Cancellation of Meeting - Notice
09/11/81 Federal Register
Contact: Cleo E. Hancock, Jr., 202-245-6097

Medicaid Program: Revocation of Sixty-Day Public Notice of Changes in Method or Level of Reimbursement - Proposed Rule
09/16/81 Federal Register
Contact: Roberta Ward, 301-597-2953, FTS 987-2953

Medicare Program: Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981 - Correction Notice
09/18/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicare Program: Inpatient Hospital Deductible for 1982 - General Notice
09/24/81 Federal Register
Contact: Guy King, 301-594-2826, FTS 934-2826

Medicaid Program: Payment for Long Term Care Facility Services and Inpatient Hospital Services; Interim Rate - Interim Final Rule with Comment Period
09/30/81 Federal Register
Contact: Alan Spielman, 301-594-4010, FTS 934-4010

Medicaid Program: Medicaid Eligibility and Coverage Criteria - Interim Final Rule with Comment Period
09/30/81 Federal Register
Contact: Elmer Smith, 301-594-9682, FTS 934-9682

Medicaid Program: Reductions in Payments to the States - Interim Final Rule with Comment Period
09/30/81 Federal Register
Contact: Charles Schreibeis, 301-597-1702, FTS 987-1702

Medicaid Program: Offset Based on Third Party Liability Recoveries Against Reductions in Medicaid Payments - Notice of Proposed Rulemaking
09/30/81 Federal Register
Contact: Charles Schreibeis, 301-597-1702, FTS 987-1702

Medicare Program: Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs - Final Notice
09/30/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

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Regulation Review - continued from page 7

Medicare Program: Schedule of Limits on Home Health Agency Costs Per Visit Effective October 1, 1981 - Final Notice
09/30/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicaid and Medicare Programs: Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs - Final Notice
09/30/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicaid Program: Freedom of Choice; Waivers of and Exceptions to State Plan Requirements - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: Stanley Katz, 301-594-9595, FTS 934-9595

Medicaid Program: Home and Community-Based Services - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: Robert Wren, 301-594-9820, FTS 934-9820

Medicare Program: Inpatient Routine Nursing Salary Cost Differential - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: William Goeller, 301-597-1802, FTS 987-1802

Medicaid and Medicare Programs: Less Than Effective Drugs and Inpatient Hospital Tests - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: Henry J. Hehir, 301-594-8561, FTS 934-8561

Medicaid Program: Miscellaneous Medicaid Provisions - Increased State Flexibility - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: Paul Riesel (for Medicaid reasonable charge limits), 301-597-1843, FTS 987-1843; Kathy Rama (for flexibility in collection of payments), 301-594-8221, FTS 934-8221; Robert Wren (for recertification), 301-594-9820, FTS 934-9820

Professional Standards Review; Professional Standards Review Organizations (PSRO) - Interim Final Rule with Comment Period
10/01/81 Federal Register
Contact: Geraldine L. Ellis, 301-594-1432, FTS 934-1432; David McNally (for Part 433), 301-597-1397, FTS 987-1397

Medicare Program: Reimbursement for Hospital-Based Physicians - Withdrawal of Final Rule
10/06/81 Federal Register
Contact: Leonard Peshkin, 301-594-1115, FTS 934-1115

Medicare Program: Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981 - Correction Notice
10/13/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

HCFA ESTABLISHES TASK FORCE ON COMPETITION

In July 1981 HCFA Administrator Davis established the HCFA Task Force on Competition to coordinate HCFA policy relating to the best methods of instilling competition into the financing and delivery of health care. Proposals being considered focus on approaches to curb the rapid rise in health care expenditures by exposing the health care sector to marketplace forces. The Task Force will enable HCFA to play a role in the development of the Department's pro-competition proposals.

The HCFA Task Force responds to the initiatives of the Departmental Task Force on Competition (DTF) established by Secretary Schweiker in May. The DTF is chaired by Robert Rubin, M.D., Assistant Secretary for Planning and Evaluation (ASPE). Its membership includes:

Pamela G. Bailey
Assistant Secretary for Public Affairs

Daniel Bourque
Deputy Executive Secretary for Health

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration

Linda Jenckes
Deputy Assistant Secretary for Legislation

C. Everett Koop, M.D.
Deputy Assistant Secretary for Health

Juan Del Real
General Counsel

Dale Sopper
Assistant Secretary for Management and Budget

The DTF's recommendations are forwarded to Secretary Schweiker for his review and decision. Dr. Rubin's competition work group in ASPE serves as primary staff to the DTF.

Both the Department's and HCFA's Task Forces on Competition have examined a series of issues designed to encourage a more competitive health care system. Some of the areas considered include tax code changes, multiple choice of health care plans, plan qualification, and the role of Medicaid and Medicare in fostering a more competitive health care environment. HCFA's Task Force provides a forum for thoughtful analysis of these issues by HCFA personnel.

The HCFA Task Force on Competition includes all Associate Administrators and representatives from the various offices and bureaus. It is chaired by Associate Administrator for Policy, Patrice Hirsch Feinstein. For more information call Wayne Taylor at 202-472-3133.

Health Care Financing R&D Reports

This is MMX's latest addition - a feature column listing research, demonstration, and statistical data published by HCFA's Office of Research, Demonstrations and Statistics (ORDS).

Listed by title are final research and statistical reports available from:

HCFA, Office of Research, Demonstrations and Statistics
1-E-9 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207
301-597-2422, FTS 987-2422

Research Reports

Health Care Financing Review - September 1981 - HCFA Pub. No. 03123
- National Health Expenditures, 1980
- Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment and Financial Experience
- An Analysis of Services Received Under Medicare by Specialty of Physician
- Individual Health Accounts: An Alternative Health Care Financing Approach
- Use and Costs Under the Iowa Capitation Drug Program

Health Care Financing Monograph
Medicare Data System - HCFA Pub. No. 03111

Health Care Financing Conference Proceedings
Issues in Physician Reimbursement - HCFA Pub. No. 03121

Health Care Financing Grants and Contracts Reports
Evaluation of the Colorado Clinical Psychology/Expanded Mental Health Benefits Experiment, Executive Summary - HCFA Pub. No. 03130
Medicaid Nursing Home Reimbursement: New York, Illinois, California Case Studies - HCFA Pub. No. 03135
An Overview of Medicaid Nursing Home Reimbursement in Seven States - HCFA Pub. No. 03134

Health Care Financing Monograph
Medicare: Hospital Use Rates of Aged Enrollees by Health Service Area, 1974-1977 - HCFA Pub. No. 03113

Statistical Reports

Health Care Financing Notes
Medicare: Summary of Use and Reimbursement by Person, 1978 - HCFA Pub. No. 03116
Medicare: Use of Hospital Outpatient Services, 1979 - HCFA Pub. No. 03136
Medicare: Use of Skilled Nursing Facility Services, 1979 - HCFA Pub. No. 03125

Health Care Financing Program Statistics
Medicare: Use of Short-Stay Hospitals by Aged Inpatients, Annual Summary, 1977 - HCFA Pub. No. 03096

Health Care Financing Trends - Summer 1981 - HCFA Pub. No. 03132
Information through March 1981 on:
. National Health Expenditures
. Community Hospital Statistics
. Health Care Prices
. Employment, Hours, and Earnings of Health Workers
. National Economic Indicators

Following is a listing of final reports that can be purchased from:

National Technical Information Services
Document Sales
5285 Port Royal Road
Springfield, Virginia 22151
703-487-4650

Other Reports

- A Primer on Quality Assurance and Cost Containment for Medical Students and Residents
- Teaching Quality Assurance and Containment: A Facility Resource
- Physician Productivity, Renumeration Method and Supplier-Induced Demand
- Study of Physician Reimbursement Under Medicare and Medicaid (Volumes I and II)
- R & D Implications For Federal Directions In Capital Financing of Health Care Services -- PB81213902
- Analysis of Physicians' Input Decisions -- PB81211971
- Third Year Evaluation of the Monroe County Long Term Care Program, Inc. -- PB81191264
- Physician Behavior Under the Medicare Assignment Option -- PB81224354
- Project Monitor For The Day Hospital in Rehabilitation Medicine -- PB81234320
- The Use of Long-Term Care and Community-Based Alternatives Among Blacks, Hispanics and Whites (Final Report) -- PB81239600
- City/University EPSDT Day Care Project 1976-1979
- Compendium of National Health Expenditures Data -- PB81149544
- Current Medicare Survey Reports: Complete Set, July 1966 through December 1977 -- PB81222523

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LITIGATION IN BRIEF

Following are recent reimbursement, coverage, and/or eligibility court decisions in civil litigation involving the Medicaid and Medicare programs. Call John Bader of HCFA's Civil Litigation Branch on 301-594-9708, FTS 934-9708, for further information about these cases and other judicial developments involving Medicaid and Medicare programs.

TWO VIEWS ON RECIPIENT'S INCOME

In a 6-3 decision, the Supreme Court reversed the Court of Appeals for the District of Columbia Circuit. It held that the HHS Secretary properly exercised the authority delegated by Congress in promulgating regulations permitting 209(b) option States to deem "excess" income of one spouse to an institutionalized spouse for purposes of determining Medicaid eligibility and the amount of assistance due the institutionalized spouse.

In Gray Panthers, the Supreme Court held that the Court of Appeals should not have invalidated 42 CFR Sections 435.734, 436.602, and 436.711. The appellate court had invalidated those regulations on the ground that the Secretary had not considered all aspects of deeming before promulgating them. According to the highest court, however, Congress had already considered all the relevant factors when it enacted the Medicaid program and permitted States to take into account the financial responsibility of spouses for each other. Furthermore, since Section 1902(a)(17)(B) of the Social Security Act gives the Secretary responsibility to define what constitutes "available" income, the Secretary's decision to require deeming had legislative support.

The Supreme Court also said that Congress itself approved deeming for income between individuals and their spouses where deeming rules existed prior to adoption of the 209(b) option. The court found that determination of need based on the use of a formula which includes deeming is not inherently wrong. Furthermore, to require costly individual determinations of need would use resources for administration that could have been spent on the needy.

In another case, the State of Alabama was rebuffed in its attempt to require all Medicaid nursing home recipients to assign to the county tax collector the right to receive all their earned and unearned income. Alabama had tried to keep pace with the soaring costs of funding the State's share of the Medicaid program by appropriating the patient's income under a new State law, Act No. 80-113. Prior to this law, Alabama deducted Medicaid patients' income from the cost of nursing home care, and sought 70 percent Federal matching funds (Alabama's Federal Medical Assistance percentage) only on the remaining cost.

Thus, in a hypothetical situation, if the monthly charges of a nursing home were $600 and a patient received $200 in assessable monthly income, the patient would be obligated to pay that $200 toward the cost of the patient's care, and the Federal and State governments would contribute a total of $400 in Medicaid costs. The Federal government would absorb 70 percent or $280, and the State 30 percent or $120.

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Litigation - continued from page 12

Under Alabama's new law, the patient's income goes directly to the State. The State uses the money to pay the cost of the patient's nursing home care as part of its matching funds. Thus, in our hypothetical situation, the overall Federal and State obligation would be the total nursing home charge ($600), with the Federal government being responsible for absorbing 70 percent or $420, and the State 30 percent or $180. By appropriating the patient's income, Alabama could transform a $120 expense into a profit of $20.

When the Secretary continued to fund its share of Alabama Medicaid under the previous Alabama law, the State sued and lost in district court. The court of appeals affirmed the district court decision and invalidated this scheme, citing 42 CFR Section 435.735 and Congress' intent in enacting the Medicaid law. The court concluded that a patient's income could be used to reduce the cost of care, but could not be appropriated by the State to reduce its contribution to those costs.

TWO VIEWS ON TERMINATION HEARINGS

The Seventh Circuit Court of Appeals recently joined several other circuits in ruling that Medicare providers are not entitled to pre-termination hearings.

Northlake Community Hospital was cited by a State certification survey team for several deficiencies which included two Life Safety Code violations. The hospital waited over six months before responding to the deficiency notice. The Department of Health and Human Services conducted an additional survey, but the deficiencies remained. A notice of termination followed.

The provider sought a temporary restraining order against the Medicare program, but the lower court refused to grant one, indicating that the provider must first exhaust administrative remedies, including the available post-termination hearing. The provider claimed that it was denied due process before it was terminated, but the court rejected that argument. The Circuit Court agreed, citing the lengthy pre-termination opportunities given providers to discuss and/or correct deficiencies.

A District Court in the same circuit, however, reached a contrary result. Relying on the Omnibus Reconciliation Act of 1980, the court in Turtle Creek Convalescent Centers, Inc. found that the provider is entitled to a hearing before an administrative law judge prior to any termination action by the Secretary.

The plaintiff, a Medicaid/Medicare skilled nursing facility and a Medicaid intermediate care facility, was about to be terminated under both programs when it obtained a court order preventing that action. After a 3-day trial, the court concluded that the Omnibus Act requires a pre-termination hearing, which will mean a further delay of 1-2 years before termination can take place.

Because HCFA believes the Omnibus Act requires such a hearing only where the Federal government wishes to terminate a facility and the State does not, the decision will probably be appealed. ■

Personnel

MEDICAID

Medical Assistance Unit Directors

William M. Mooney - Arkansas Department of Social Services
Jake Canova - Louisiana Office of Family Security
Gretchen Engquist - Missouri Department of Social Services
Gary Blewett - Montana Department of Social and Rehabilitation Services
Melvin Clothier - Nebraska Department of Public Welfare
John F. Fortune - Tennessee Department of Public Health
Sharon Wasek - Utah Department of Health
Gerald J. Reilly - Washington Department of Social and Health Services

Single State Agency Directors

Thomas L. Purce - Idaho Department of Health and Welfare
Donald L. Blinzinger - Indiana Department of Public Welfare
Gerald J. Reilly - Washington Department of Social and Health Services

MEDICARE

Part B Carrier

Neil Bass - Second Vice President and Chief Medicare Administrator, Occidental Life Insurance Company of California

HCFA

Central Office

Patrice Hirsch Feinstein - Associate Administrator for Policy
Aris T. Allen, M.D. - Director, Health Standards and Quality Bureau
Tera S. Younger - Director, Bureau of Program Operations
Richard Teske - Director, Office of Intergovernmental Affairs
John Saville - Director, Office of Field Operations
Harvey Brook - Deputy Director, Office of Field Operations
John Jansak - Acting Director, Office of Program Administration
Will Wolstein - Acting Director, Medicaid/Medicare Management Institute
Kenneth Koppenhoefer - Acting Director, Office of Standards and Performance Evaluation

Legislative Ledger

- On July 31, S.1566 was introduced to the Committee on Finance amending provider initiatives to increase the Medicare assignment rate for physicians, and changing the way Medicare reimburses physicians for services rendered. A relative value scale (RVS) will be used to calculate payments to Medicare physicians. Once the RVS is determined, dollar multipliers will then be used to calculate per centum increases and decreases in the fees paid by Medicare.

- Bill S.1536 introduced on July 29 offers a comprehensive plan to resolve both the short and long term financial problems facing social security programs (the old age, survivors, and disability insurance program, and the Medicaid program) without cutting benefits to recipients. It also authorizes interfund borrowing among the three social security trust funds when any one of the funds falls below 25 percent of a year's expenses. Any funds borrowed are to be repaid to the lending trust fund with interest.

- On July 22, Senator John Heinz and several other senators introduced a bill to the Committee on Finance which changes Medicare's method of reimbursement for competitive medical plans. It allows Medicare beneficiaries to enroll on a voluntary basis in health maintenance organizations (HMOs) and other prepaid health systems. Under S.1509, the elderly can choose from a variety of health care delivery systems based on their individual needs. This bill also stimulates competition among alternative health care systems, and holds down health care costs through greater utilization of more efficient health care delivery systems.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717. ■

Providing Alcoholism Services - continued from page 4

freestanding service centers compared to traditionally covered services, such as hospitals;

- whether reimbursement to the new providers would result in a shift of utilization from hospitals to freestanding facilities; and,

- whether the emphasis on using nonphysician personnel (e.g., alcoholism counselors) would affect the administration and delivery of care.

Under this demonstration the uniform Medicaid and Medicare benefits package is: alcohol detoxification services - no limit; inpatient alcoholism treatment services - up to 30 days per calendar year, including care in a halfway house; outpatient alcoholism treatment services - up to 45 visits per calendar year; and, halfway houses - depending on qualifications and client need, one or all of the above services.

During the demonstration's first six to nine months, the grantee will detail various aspects of the project and train provider personnel. HCFA's Bureau of Support Services, Office of Direct Reimbursement will be the Medicare fiscal intermediary. The Office of Research, Demonstrations and Statistics, Ambulatory Services Branch will administer and monitor the demonstration grants.

Lawrence Johnson and Associates, Inc. will evaluate the demonstration. They will design a uniform evaluation component that will be installed in the demonstration States during the initial six to nine months. Contact: Dr. Andrew Solarz, 301-594-0397, FTS 934-0397.■

ACTION TRANSMITTALS

These Action Transmittals were issued by HCFA between August and October 1981.

AT-81-30 Title XIX, Social Security Act, Section 1903(g) - Utilization Control (UC) Validation Survey for the Quarter Ending June 30, 1981 of Mental Health Services Provided in Mental Hospitals (MH), including Skilled Nursing Facilities and Intermediate Care Facilities Classified as Institutions for Mental Diseases (IMD) and Psychiatric Facilities Serving Individuals Under 21. The survey will be conducted in 10 selected States. These States are California, Connecticut, Delaware, Kentucky, Louisiana, Michigan, Nebraska, New York, North Dakota, and Oregon. (Refer to: Sections 1903(g)(1)(A) and (B) and 1903(g)(2) of the Social Security Act; 42 CFR 456.160, 456.170, 456.180, and 456.181)

AT-81-31 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated or Where Effectuated Sanction was Withdrawn (Refer to: Sections 506(f)(2), 1128(a), 1160, 1862(d), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-32 Providing Chain Organization Home Office Audit: Results Among Affected State Agencies (Refer to: 1902(a)(30), requires that payment for necessary services do not exceed reasonable charges consistent with efficiency, economy, and quality of care; 42 CFR 447.261, reasonable cost payment for inpatient hospital services; 42 CFR 447.284, purchases from related organizations, limit on costs; 42 CFR 447.290-296, audits; 42 CFR 447.352, other noninstitutional services, upper limits)

AT-81-33 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated or Where Effectuated Sanction was Withdrawn (Refer to: Sections 506(f)(2), 1128(a), 1160, 1862(d), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-34 Title XIX of the Social Security Act: Preprinted State Plan Amendment on Reimbursement for Clinical Laboratory Services (Refer to: 42 CFR 447.10 and 447.342; Federal Register, on Monday, August 24, 1981, 46 FR 42669, effective for services provided under State plan on or after July 1, 1981)

AT-81-35 Title XIX, Social Security Act: Section 9 of Public Law 96-420 Concerning Payments Distributed Under the Main Indian Claims Settlement Act of 1980

AT-81-36 Draft List of Revised Definitions of Federal Medicaid Reporting Categories

INFORMATION MEMORANDUMS

This October Information Memorandum was the only one published since those listed in issue #5/6.

IM-81-13 Public Law 96-499 - New Buy-In Agreements

INDIVIDUALS AND GROUPS AWARDED

FOR OUTSTANDING SERVICE TO BENEFICIARIES

During HCFA's Fourth Annual Honor Awards Ceremony in Baltimore on September 18, Administrator Davis commended the award recipients for their contributions to the health needs of the aged, poor, and disabled.

The 1981 Beneficiary Services Award was presented to William J. Collins, HCFA, Division of Program Operations, Seattle regional office, "in recognition of leadership in the creation and implementation of methods of expanding public awareness and interest in the health of children." This special award is presented to a HCFA employee who has demonstrated keen sensitivity to the needs of Medicaid and Medicare beneficiaries.

Beneficiary Services Certificates of Merit were presented to individuals or groups of individuals both within and outside of HCFA for either outstanding performances in service to beneficiaries or for a major contribution in the area of beneficiary services.

Recipients were: JENNIE BEASLEY, Oklahoma Department of Human Services; MARY BONNICK, Public Service Director, KDFW-TV, Dallas, Texas; KEN COTTON, National Retired Teachers Association, American Association of Retired Persons, Phoenix, Arizona; EDWARD J. DUGAN, Delaware Blue Cross/Blue Shield; JACK GAMBLE, Prudential Insurance Company, Linwood, New Jersey; RICHARD GREENBERG, Occidental Life Insurance Company, Los Angeles, California; VIRGINIA GWALTNEY, Florida Department of Health and Rehabilitation Services; SARA ROSENBAUM, Children's Defense Fund, Washington, D.C.; LOIS SHOREY, National Retired Teachers Association, American Association of Retired Persons, Billings, Montana; RUTH SOWERS, Senior Citizens Action Council, Rochester, New York; DOROTHY WALKER, National Council of Senior Citizens, Detroit, Michigan; MYRL WEINBERG, Association for Retarded Children, Washington, D.C.; AMERICAN ASSOCIATION OF RETIRED PERSONS, CHAPTER 1678, Billings, Montana.

A reception was held immediately following the Awards Ceremony in honor of these recipients.

R and D Reports From NTIS - continued from page 11

- A Case Study Prospective Reimbursement in Washington (Volume VIII) -- PB80195548
- Blue Cross of Western Pennsylvania Prospective Budget Program Final Report for the Period July 1976 through June 30, 1979 -- PB81166811
- Comparison of Cost and Budget Incidence of Government Medical Care Program, FY 1966 and 1969 -- PB81145229
- Personal Health Care Expenditures by State, Volume II, Public and Private Funds 1966 and 1969 -- PB81144826
- Alternate Approaches to Physician Reimbursement Under Medicare: A Simulation on Wueller Charlotte F/CUNYF/79 -- PB81121725

CAPITALIZING STATE RESOURCES

M/MMI's Corrective Action Projects Division (CAPD) provides technical assistance and professional consultative services to State Medicaid agencies. CAPD focuses its efforts on resolving problems which significantly contribute to Medicaid quality control errors. Through CAPD, States are afforded the expertise needed to implement operational improvements in their programs in third party liability (TPL), data exchange, and error prone profiling/eligibility management. For additional information about CAPD and the services it offers, call Arthur Pergam, CAPD Director, 301-594-8942, FTS 934-8942.

CAPD AND MONTANA SRS COMPLETE SURVEY TO OBTAIN MANAGEMENT DATA

CAPD and the Montana Department of Social and Rehabilitative Services (SRS) recently completed a joint eligibility management improvement project. The project centered on a mail survey of administrative/management practices and eligibility determination processes utilized in seventeen pre-selected Montana counties. The survey helped the State obtain management data, and assisted them in identifying problems in program administration and management. Montana's SRS then developed a specific corrective action plan to address problems identified.

The survey was sent to eight counties comprising 85 percent of the State's public assistance caseload, and nine smaller counties. The survey was conducted through a three-part questionnaire targeted at county personnel most involved in Medicaid operations - county director, eligibility technician supervisor, and eligibility technician. CAPD reviewed and analyzed responses from each respective level. CAPD then identified similarities and differences between counties and within individual counties. Attention was focused on the frequency of a given response and the variety of responses among workers in a given county. Each county's administrative practices were compared with that county's MQC error rate to determine if patterns of error rates could be associated with certain administrative practices.

The survey's findings revealed that administrative and operational procedures were applied inconsistently throughout the counties; initial and ongoing training for all levels of personnel varied from county to county; and, an inordinate number of forms were needed to process eligibility determinations. Comparisons between county practices and MQC error rates were inconclusive because the MQC case sample selected for most counties was too small to be statistically valid for such comparisons.

In response to these findings, CAPD recommended that the State: establish clear standard operational procedures for all counties; develop a State oriented training program which clearly defines the agency's operational procedures and position responsibilities and duties; and, review current application forms to determine the feasibility of a consolidated application form for all SRS programs. Contact: Ellen McNeill, 301-594-8645, FTS 934-8645.

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WASHINGTON STATE AND SEATTLE RO REPORT ON JOINT TPL PROJECT

The report, Third Party Liability in the Medicaid Program: A Seattle Case Study, is now available. It describes a third party liability (TPL) case study conducted by the Seattle HCFA regional office and the State of Washington.

The report's executive summary states: "The State of Washington saves three percent of the total cost of its Medicaid program by pursuing TPL. The State spends only $1 for every $36 it saves on TPL. These measurements rank Washington among the better TPL programs in the country. Nevertheless, our study shows that in the city of Seattle alone, 2,700 Medicaid cases could have yielded an additional $1 million in third party recoveries if TPL had been identified and recovered on time. Our data also show that 86 percent of the resources missed by the existing third party program were related to the employment health insurance of a Medicaid recipient, an AFDC absent parent, or some other relative. Only 14 percent of the unrecovered resources identified by the project were not related to employment health insurance."

For a copy of this report, contact Steve Moses or Jim Benz from Seattle's RO at 206-442-7806, FTS 399-7806. ■

CAPD Activities - continued from page 18

HCFA/HIAA/BC-BS TASK FORCE COMPLETES PLANS FOR DATA MATCH PILOT

A combined HCFA, Health Insurance Association of America (HIAA), and Blue Cross/Blue Shield (BC/BS) task force is conducting a study to determine the potential for automating eligibility/enrollment file comparisons between Medicaid and health insurance carriers. (Refer to MMX article, "Data Match Protocol," Issue #6, September 1980.) The task force has completed plans for a "pilot" data match to determine the practicality and effectiveness of data matches in identifying Medicaid recipients having third party resources.

The task force has also developed a proposal that documents the objectives and methodologies for testing and selecting test States. Currently, research to facilitate selection of test States is underway. For further information concerning this project call Jane Herlocker, 301-594-9577, FTS 934-9577. ■

THIRTY-SIX STATES RECEIVE INCREASED FFP FOR MMIS

West Virginia has recently been approved by HCFA for 75 percent Federal Financial Participation (FFP) for operation of a mechanized claims processing and information retrieval system. This brings the total to 36 States receiving 75 percent FFP. The increased FFP is available to a State for operating an approved Medicaid Management Information System (MMIS).

Pennsylvania's MMIS is currently being reviewed for approval of 75 percent FFP. New York State is progressing towards receiving total 75 percent FFP approval on the five remaining regions in development.

Seven States are in the planning, designing, and development stages for an MMIS. Ten States/Territories do not have an operating MMIS. For further information contact Bea Smith, Office of Methods and Systems, 301-594-8441, FTS 934-8441. ■

MEDICARE CONSULTATIVE ACTIVITIES

RESULTS FROM SEPTEMBER'S CARRIER REPRESENTATIVE GROUP (CRG) MEETING

HCFA Administrator, Dr. Carolyne K. Davis, and Associate Administrator for Operations, George A. Thompson, presented the opening remarks at the CRG meeting on September 18, 1981. Dr. Davis spoke about the budgetary climate and the attempts being made to reduce Medicare contractor operational responsibilities to respond to the budgetary shortfall.

There was a major discussion of budget issues. This included the listing of specific cost reduction measures being taken due to the budgetary restrictions. There was also a report on the creation of a special advisory group known as the Medicare Contractor Cost/Burden Reduction Task Force to work with central office on reducing contractor burdens. The task force held its initial meeting in Chicago on October 21-22. Its members, both carrier and intermediary representatives, will address the cost burdens of the entire Medicare operational environment. The next CRG meeting is scheduled for January 14, 1982.

CRG MEETING SET FOR JANUARY 14

The next CRG meeting will be held on January 14, 1982. Participants will discuss carrier budgetary issues, carrier performance standards, and activities of the Cost/Burden Reduction Task Force.

RECAP OF NOVEMBER'S FISCAL INTERMEDIARY GROUP (FIG) MEETING

At the FIG meeting on November 12, 1981, the major thrust of the agenda items dealt with the impact of severe budgetary restraints on intermediary operations.

The agenda included discussion of budgetary issues for fiscal year 1982, the impact of budgetary reductions on the Contractor Performance Evaluation Program (CPEP) and HCFA's attempt to give the intermediaries some relief by the activities of the Medicare Contractor Cost/Burden Reduction Task Force.

For more information, call Paul Beller of the Medicaid/Medicare Management Institute, at 301-594-9455, FTS 934-9455.

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Department of Health and Human Services
Richard S. Schweiker, Secretary

Health Care Financing Administration
Carolyne K. Davis, Ph.D., Administrator
George A. Thompson, Associate Administrator
for Operations

Bureau of Program Operations
Tera S. Younger, Director

Medicaid/Medicare Management Institute
Will Wolstein, Acting Director

Editor, Joan F. Kahl
Graphics, Mary Lou Hutchison

Address Inquiries to: Editor
Medicaid Medicare Exchange
MMMI/HCFA
389 East High Rise
6325 Security Blvd.
Baltimore, MD 21207
301-594-8699
FTS-934-8699